DD/S 69-2172

DD/S REGISTRY
FILE 6 Medical

8 May 1969

MEMORANDUM FOR: Deputy Director for Support

SUBJECT : Medical History and Examination Forms

1. This memorandum contains a recommendation in Paragraph 5 for the approval of the Deputy Director for Support.

2. You will recall that, on 17 January 1967, the Chairman of the Civil Service Commission withdrew authorization of the then Standard Form 89, Report of Medical History, for use by civilian components of the Government. Soon after, we devised a substitute form which you approved and a copy of which was sent to the Commission for their information. We have been using this substitute form to date. (Attachment A)

3. Recently, the Civil Service Commission has come out with a new medical history form, Optional Form 58, which is essentially the old form with questions and areas removed that provoked previous criticism. We have reviewed this revised version and believe that it could serve our purpose. While it is lacking in several respects, it does have the advantages of being standardized and approved by the Commission. (Attachment B)

25X1

[redacted]

SIGNED

JOHN R. TIETJEN, M. D.
Director of Medical Services

Attachments

SECRET

SUBJECT: Medical History and Examination Form

25X1

The recommendation in Paragraph 5 is approved.

SIGNED R. L. Bannerman

12 MAY 1969

R. L. BANNERMAN
Deputy Director for Support

Date

OMS/JRTietjen:mam
Distribution:
Orig & 1 - D/MS
2 - DD/S ✓ Chrono, Subject
1 - PA/OMS
1 - C/SPD/OMS
1 - C/CD/OMS
1 - AC/SD/OMS
1 - Registrar/OMS

MEDICAL RECORD (To be completed by applicant)

1. NAME	HEIGHT	2 ADDRESS
3. SEX / 4. MARITAL STATUS / 5. DATE OF BIRTH / 6. NO. OF CHILDREN	WEIGHT	

MEDICAL HISTORY

6. CHECK BELOW IF YOU HAVE EVER HAD ANY OF THE FOLLOWING. EXPLAIN ALL CHECK MARKS ON REVERSE SIDE. IF NONE CHECK HERE ☐

1 __ EPILEPSY	8 __ BLOODSPITTING	15 __ VARICOSE VEINS	22 __ FAINTING SPELLS	29 __ CANCER OR TUMORS	36 __ FREQUENT SORE THROAT
2 __ ARTHRITIS	9 __ POLIOMYELITIS	16 __ SWOLLEN GLANDS	23 __ RECTAL TROUBLE	30 __ FREQUENT INDIGESTION	37 __ CHOREA (ST. VITUS DANCE)
3 __ DIABETES	10 __ TUBERCULOSIS	17 __ TYPHOID FEVER	24 __ RHEUMATIC FEVER	31 __ PEPTIC (STOMACH) ULCER	38 __ DERMATITIS (SKIN TROUBLE)
4 __ PARALYSIS	11 __ DISCHARGE (EAR)	18 __ HEART TROUBLE	25 __ KIDNEY TROUBLE	32 __ BACKACHE OR SPRAIN	39 __ FREQUENT NOSE BLEEDING
5 __ JAUNDICE	12 __ EARACHES	19 __ CHRONIC COUGH	26 __ VENEREAL DISEASE	33 __ ASTHMA OR HAYFEVER	40 __ FREQUENT HEADACHES OR DIZZINESS
6 __ MALARIA	13 __ PLEURISY	20 __ HERNIA (RUPTURE)	27 __ SHORTNESS OF BREATH	34 __ DIFFICULTY OF URINATION	41 __ NERVOUS OR MENTAL BREAKDOWN
7 __ GOUT	14 __ PNEUMONIA	21 __ FREQUENT COLDS	28 __ CHRONIC CONSTIPATION	35 __ HIGH BLOOD PRESSURE	

6A. ILLNESSES NOT LISTED ABOVE	6B. DISEASES OF CHILDHOOD

7. GIVE DETAILS OF ILLNESS, OPERATIONS *(Include tonsils)*, INJURIES *(Include fractures)*

8. HAVE YOU ANY IMPAIRMENT OF SIGHT OR HEARING	9. HAS YOUR WEIGHT CHANGED IN LAST TWO YEARS ☐ INCREASED ☐ DECREASED HOW MUCH _____ LBS	10. MENSTRUAL HISTORY *(Include date of last period)*
11. HAVE YOU BEEN VACCINATED FOR SMALLPOX ☐ YES ☐ NO DATE	12. WHAT OTHER VACCINATIONS OR INOCULATIONS HAVE YOU HAD	13. HAVE YOU EVER USED ALCOHOLIC OR MALT LIQUORS TO EXCESS
14. HAVE YOU EVER RECEIVED TREATMENT FOR ALCOHOL OR DRUG HABIT	15. WHEN DID YOU LAST CONSULT A PHYSICIAN *(Give name of physician and date)*	16. DO YOU SMOKE *(If so how much)*

17. MILITARY SERVICE

1. YEARS OF SERVICE _____ 2. BRANCH OF SERVICE _____ 3. DATE OF DISCHARGE _____

4. REASON FOR DISCHARGE _____ 5. ARE YOU APPLYING FOR OR RECEIVING ANY GOVERNMENT PENSION OR DISABILITY PAYMENTS _____ 5A. IF SO, WHAT PERCENTAGE OF DISABILITY _____

6. PRESENT DRAFT MEDICAL STATUS _____ 7. IF 4F, FOR WHAT REASON _____

18. HAVE YOU EVER BEEN REFUSED INSURANCE	19. HAVE YOU ANY COMPENSATION CLAIM PENDING

20. FAMILY RECORD AND MEDICAL HISTORY

FAMILY *(Include siblings)*	AGE	LIVING *(State of health)*	DECEASED *(Cause)*	AGE AT DEATH
FATHER				
MOTHER				
HUSBAND				
WIFE				

HAS ANY MEMBER OF YOUR FAMILY EVER HAD:			
DISEASE	YES	NO	MEMBER OF FAMILY
TUBERCULOSIS			
CANCER			
INSANITY			
EPILEPSY			
DIABETES			
APOPLEXY *(Stroke)*			
HEART TROUBLE			
KIDNEY TROUBLE			
HIGH BLOOD PRESSURE			

I certify that the foregoing statements are true to the best of my knowledge and belief. I understand that leaving out or misrepresenting facts called for above may be the cause for refusal of employment or separation from the Organization.

I hereby grant permission to the examining physician to disclose any and all information herein or hereinafter furnished by me to the Organization as may be deemed necessary.

_____ DATE

_____ SIGNATURE OF APPLICANT

Att A

2223 4-67

STAT

Next 6 Page(s) In Document Denied